

**U.S. Department of Labor**

Office of Administrative Law Judges  
800 K Street, NW, Suite 400-N  
Washington, DC 20001-8002

(202) 693-7300  
(202) 693-7365 (FAX)



**Issue Date: 09 September 2005**

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In the Matter of:

LLOYD BLANKENSHIP  
Claimant

Case No.: 2004 BLA 6

v.

DOUBLE B MINING, INC.  
Employer

and

DIRECTOR, OFFICE OF WORKERS'  
COMPENSATION PROGRAMS  

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Party in Interest

Appearances: Mr. W. Andrew Delph, Jr., Attorney  
For the Claimant

Ms. Lucy G. Bowman, Attorney  
For the Employer

Before: Richard T. Stansell-Gamm  
Administrative Law Judge

**DECISION AND ORDER ON REMAND –  
AWARD OF BENEFITS**

This matter involves a claim filed by Mr. Lloyd Blankenship for benefits under the Black Lung Benefits Act, Title 30, United States Code, Sections 901 to 945 (“the Act”). Benefits are awarded to persons who are totally disabled within the meaning of the Act due to pneumoconiosis, or to survivors of persons who died due to pneumoconiosis. Pneumoconiosis is a dust disease of the lung arising from coal mine employment and is commonly known as “black lung” disease.

**Procedural Background**

Initial District Director Adjudication

Mr. Blankenship’s decades long journey to benefits began on April 9, 1991 when he filed his claim for black lung disability following the removal of a portion of his left lower lung in

September 1990 (DX 1).<sup>1</sup> After two conferences, the District Director denied Mr. Blankenship's claim for failure to prove total disability due coal workers' pneumoconiosis in May 1992 (DX 26 and DX 38). On August 25, 1992, based on Mr. Blankenship's appeal, the District Director forwarded the case to the Office of Administrative Law Judges ("OALJ") for a hearing (DX 27, DX 47, and DX 53).

#### First Administrative Law Judge Decision

On April 20, 1993, Administrative Law Judge Robert J. Shea conducted a hearing (DX 67). Subsequently, finding Dr. Robinette's medical opinion most probative, Judge Shea concluded that Mr. Blankenship was totally disabled by coal workers' pneumoconiosis under the provisions for 20 C.F.R. § 718.204 (c) (4). The date of entitlement was April 9, 1991 (DX 70). The Employer appealed the award of benefits on November 21, 1994 (DX 72).

#### First Benefits Review Board Decision

On July 27, 1995, the Benefits Review Board ("BRB" and "Board") vacated Judge Shea's award of benefits and remanded the claim for further consideration. The Board concluded Dr. Robinette's opinion was insufficient to establish that Mr. Blankenship suffered a totally disabling respiratory disease under 20 C.F.R. § 718.204 (c) (4). At the same time, the BRB observed that the medical evidence in the record warranted evaluation under 20 C.F.R. § 718.304, which establishes an irrebuttable presumption of total disability if complicated coal workers' pneumoconiosis is present. The Board further advised that if the presence of complicated coal workers' pneumoconiosis was not established, then re-evaluation of total disability under 20 C.F.R. § 718.204 (c) (4) would be necessary (DX 88).<sup>2</sup>

#### Second Administrative Law Judge Decision

Since Judge Shea was no longer available, Administrative Law Judge C. Richard Avery re-evaluated the claim and awarded benefits on July 15, 1996. Based on a pathology report from Mr. Blankenship's lung surgery in 1990 which noted the presence of anthrasicosis pneumoconiosis with massive fibrosis and a two to three centimeters mass, Judge Avery concluded Mr. Blankenship had complicated pneumoconiosis, thereby invoking the irrebuttable presumption of total disability due to pneumoconiosis under 20 C.F.R. § 718.304. In reaching his conclusion, Judge Avery concluded Dr. Hansbarger's requirement that the pathological mass must exceed two centimeters was irrelevant. Although the preponderance of radiographic evidence did not indicate the presence of large opacities associated with complicated pneumoconiosis, Judge Avery gave greater probative weight to the pathology findings. The date of entitlement remained April 9, 1991 (DX 97). On August 2, 1996, the Employer again appealed the award of benefits (DX 98).

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<sup>1</sup>The following notations appear in this decision to identify exhibits: DX - Director exhibit; EX - Employer exhibit; CX - Claimant exhibit; and, TR - Transcript.

<sup>2</sup>In the absence of a specific appeal, the Board affirmed Judge Shea's findings that Mr. Blankenship had 23 years of coal mine employment and that total disability was not established under 20 C.F.R. §§ 718.204 (c) (1) - (3).

### Second Benefits Review Board Decision

On April 29, 1997, the Benefits Review Board affirmed Judge Avery's award of benefits (DX 112). After the Board denied a Motion for Reconsideration in December 1997, the Employer appealed on February 13, 1998 (DX 113, DX 114, and DX 116).

### U.S. Court of Appeals for the Fourth Circuit Decision<sup>3</sup>

On May 21, 1999, the United States Court of Appeals for the Fourth Circuit vacated Judge Avery's award of benefits and remanded the case for further adjudication.<sup>4</sup> Based on its interpretation of the three methods available under 20 C.F.R. §718.304 to prove the presence of complicated pneumoconiosis, the court concluded that an equivalency determination was necessary. Specifically, the court directed the administrative law judge to determine whether the 1.3 centimeter lesion discovered on biopsy would be the equivalent of a radiographic opacity greater than one centimeter (DX 121). On July 22, 1999, the Benefits Review Board remanded the case to the OALJ (DX 122).

### Third Administrative Law Judge Decision

After reopening the record in August 1999 and considering additional medical opinion, Judge Avery again awarded black lung disability benefits to Mr. Blankenship on February 18, 2000, with an effective date of April 9, 1991.<sup>5</sup> Finding Dr. Robinette's opinion more probative and noting that a lateral chest x-ray disclosed the presence of a four centimeter mass, Judge Avery concluded that the sufficient evidence existed to conclude Mr. Blankenship had complicated pneumoconiosis (DX 127 and DX 136). The Employer appealed on March 3, 2000 (DX 137).

### Third Benefits Review Board Decision

On June 20, 2001, while generally upholding Judge Avery's findings, the Benefits Review Board nevertheless remanded the case so that Judge Avery could adjudicate the medical evidence as required by *Eastern Associated Coal Corp. v. Director, OWCP [Scarbro]*, 220 F.3d 250 (4th Cir. 2000) (DX 164).<sup>6</sup> The Employer filed a Motion for Reconsideration on July 16, 2001, which was denied on December 6, 2001 (DX 167 and DX 170).

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<sup>3</sup>177 F. 3d 240 (4th Cir. 1998).

<sup>4</sup>Due to this decision, the U.S. Department of Labor stopped the payment of interim black lung disability benefits (DX 121).

<sup>5</sup>In light of Judge Avery's decision, interim black lung disability benefits were resumed in July 2000 (DX 151).

<sup>6</sup>In June 2001, interim benefits were again suspended (DX 165).

### Additional Administrative Law Judge Actions

On March 19, 2002, because the record had been reopened, Dr. Robinette had continued to treat Mr. Blankenship, and the Employer requested a hearing, Judge Avery ordered the case returned to docket for reassignment to another administrative law judge (DX 183).

Having been assigned the case and after setting a hearing date for July 2002, Administrative Law Judge Edward Terhune Miller continued the hearing on June 26, 2002 (DX 190 and DX 191). When Judge Miller eventually conducted a hearing in December 2002, he and the parties agreed that the record needed to be returned to the District Director for organization and identification purposes (DX 201). On December 20, 2002, Judge Miller remanded the case to the District Director (DX 203).

### Second District Director Determination

On May 16, 2003, the District Director awarded black lung disability benefits to Mr. Blankenship. The Director concluded the preponderance of the more probative evidence established the existence of complicated coal workers' pneumoconiosis. The effective date of the benefits was April 1, 1991 (DX 211). On May 19, 2003, the Employer requested reconsideration (DX 213). After again reviewing the record, the District Director opined Mr. Blankenship was entitled to benefits and initiated interim benefits (DX 214 and DX 215). The case was forwarded to the OALJ on September 23, 2003 (DX 217).

### Present Adjudication

After one continuance and pursuant to Notice of Hearing, dated March 17, 2004 (ALJ I), I conducted a hearing in Abingdon, Virginia on June 8, 2004. My decision in this case is based on the hearing testimony and the documents admitted into evidence: DX 1 to DX 219, CX 1 to CX 3, and EX 1.

## **FINDINGS OF FACT AND CONCLUSIONS OF LAW**

### **Stipulations of Fact**

At the hearing, the parties stipulated that: a) Mr. Lloyd had post-1969 coal mine employment; b) by at least September 24, 1996, Mr. Lloyd Blankenship had complicated pneumoconiosis; c) Double B Mining is the responsible operator; d) and, Mrs. Blanche Blankenship is a dependent for the purposes of augmenting any benefits that may be payable under the Act (TR, pages 16 to 19).

### **Coal Miner's Background**

Born April 21, 1935, Mr. Lloyd Blankenship mined coal in low seams from 1971 to 1973, 1976 to 1981, 1982 to 1983, and September 1984 through August 1990. In his last coal mine job, Mr. Blankenship was a mine foreman. In that capacity, he filled in for absent miners and worked various jobs in the mine. When he developed lung problems in the summer of 1990,

Mr. Blankenship stopped mining coal. Mr. Blankenship first married Mrs. Blanche Blankenship on December 27, 1966. In October 1992, they divorced. Several years later, on April 22, 1999, Mr. Lloyd Blankenship and Mrs. Blanche Blankenship remarried (DX 1, DX 3, DX 4, DX 8, TR, page 37, and DX 119A).

### **Length of Coal Mine Employment**

At the hearing, Employer's counsel was unable to stipulate to the length of Mr. Blankenship's coal mine employment. As noted in footnote two, during its first review of this case, the Benefits Review Board affirmed Judge Shea's finding that Mr. Blankenship had 23 years of coal mine employment. Based on my review of the record, I conclude that Mr. Blankenship had at least 18 years of coal mine employment.

### **Adjudicative Comment**

Prior to the Employer's stipulation before me that Mr. Blankenship had complicated pneumoconiosis, the principal issue in this case had been whether the pathology samples obtained during the September 1990 lung operation established the presence of complicated pneumoconiosis. As set out in the procedural history, U.S. Circuit Court of Appeals remanded this case in order that the administrative law might determine whether the biopsy lesions would be the equivalent to a radiographic opacity greater than one centimeter. After Judge Avery attempted to comply with that remand, the Benefits Review Board sent the case back for further consideration in accordance with the adjudicative principles established by *Scarboro*. Although the issue in this case has since shifted to date of entitlement, my determination of the present issue will nevertheless include the *Scarboro* principles.

### **Entitlement to Benefits**

To receive black lung disability benefits, a claimant must four basic conditions, or elements, a claimant must prove by preponderance of the evidence four basic conditions or elements. First, the miner must establish the presence of pneumoconiosis.<sup>7</sup> Second, if a determination has been made that a miner has pneumoconiosis, it must be determined whether the miner's pneumoconiosis arose, at least in part, out of coal mine employment.<sup>8</sup> Third, the miner has to demonstrate he is totally disabled.<sup>9</sup> And fourth, the miner must prove the total disability is due to pneumoconiosis.<sup>10</sup>

The regulation, in part, at 20 C.F.R. § 718.304, provides that if a claimant is able to establish the presence of complicated pneumoconiosis, then an irrebuttable presumption of total disability due to pneumoconiosis is established (emphasis added). Based on the parties'

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<sup>7</sup>20 C.F.R. § 718.202.

<sup>8</sup>20 C.F.R. § 718.203 (a).

<sup>9</sup>20 C.F.R. § 718.204 (b).

<sup>10</sup>20 C.F.R. § 718.204 (a).

stipulation of fact that Mr. Blankenship has complicated pneumoconiosis, under the provisions of 20 C.F.R. § 718.304, he has established the first element of entitlement.

Having proven the presence of pneumoconiosis, Mr. Blankenship must next establish that his pneumoconiosis arose, at least in part, out of coal mine employment. According to 20 C.F.R. §718.203 (b), if a miner who is suffering from pneumoconiosis was employed for ten years or more in one or more coal mines, there is a rebuttable presumption that pneumoconiosis arose out of such employment. Based on the Benefits Review Board's affirmation and my finding that Mr. Blankenship has at least 18 years of coal mine employment, he is entitled to the regulatory presumption. While the presumption of pneumoconiosis arising out of coal mine employment is rebuttable, my review of the record indicates a dearth of evidence to suggest that Mr. Blankenship's pneumoconiosis is unrelated to his coal mine employment. As a result, the causation presumption under 20 C.F.R. § 718.203 (b) has not been rebutted and I find Mr. Blankenship's pneumoconiosis is due to his coal mine employment.

The last two requisite elements of entitlement are total disability and total disability due to pneumoconiosis. Again, through the parties' stipulation that Mr. Blankenship has complicated pneumoconiosis, he is able to invoke the 20 C.F.R. § 718.304 irrebuttable presumption that he is totally disabled due to pneumoconiosis. Consequently, Mr. Blankenship has also established these last two requisite elements and thus his entitlement to black lung disability benefits under the Act.

#### **Issue – Date of Entitlement**

At the June 2004 hearing, based on more recent medical review, Employer's counsel indicated that the presence of complicated pneumoconiosis was no longer being contested. However, the Employer maintains sufficient evidence of complicated pneumoconiosis did not exist until a September 24, 1996 chest x-ray was developed; thereby establishing an entitlement date of September 24, 1996. Claimant's counsel disagrees. Based on an August 1990 biopsy and medical opinion, the Claimant believes his entitlement should start in the month he filed his claim, April 1991. Thus, based on the parties' representations, the issue in this case is whether the onset date for Mr. Blankenship's complicated pneumoconiosis predates September 24, 1996.

Under 20 C.F.R. § 725.503 (b) in the case of a coal miner who is totally disabled due to pneumoconiosis, benefits are payable from the month of onset of total disability. When the evidence does not establish when the onset of total disability occurred, then benefits are payable starting the month the claim was filed. The BRB has placed the burden on the miner to demonstrate the onset of total disability. *Johnson v. Director, OWCP*, 1 B.L.R. 1-600 (1978). Placing that burden on the claimant makes sense, especially if the miner believes his total disability arose prior to the date he filed his claim. In that case, failure to prove a date of onset earlier than the date of the claim means the claimant receives benefits only from the date the claim was filed. The BRB also stated in *Johnson*, "[c]learly the date of filing is the preferred date of onset unless evidence to the contrary is presented."

At the same time, a miner may not receive benefits for the period of time after the claim filing date during which he had not yet become totally disabled. *Lykins v. Director, OWCP*, 12

B.L.R. 1-181, 1-183 (1989). One example is the situation in *Rochester and Pittsburgh Coal Co. v. Krecota*, 868 F.2d 600 (3d Cir. 1989) where after the miner filed his claim, the initial probative medical opinions provided some evidence that the miner was not totally disabled, yet the administrative law judge found a subsequent evaluation did establish total disability and then set the entitlement date as the date of the claim. The appellate court affirmed the finding of total disability but believed the administrative law judge erred by awarding benefits from the date of the claim because he had not considered whether the earlier medical evaluations indicated that the pneumoconiosis had not yet progressed to a totally disabling stage. In other words, if evidence shows an identifiable period of time where a miner was not totally disabled by pneumoconiosis that is subsequent to the date the miner filed his claim and prior to a firm medical determination of total disability, then it is inappropriate to award benefits from the month the claim was filed.

However, if no intervening medical evidence raises the possibility of total disability not being present between the claim filing date and the first medical evaluation establishing total disability, then a different set of principles is applicable. In this situation, when the first medical examination after the claim is filed leads to a finding of total disability, the date of the examination does not necessarily establish the month of onset of total disability. Instead, it only indicates that some time prior to the exam, the miner became totally disabled. *See Tobrey v. Director, OWCP*, 7 B.L.R. 1-407, 1-409 (1985) (the date the claimant is “first able to muster evidence of total disability is not necessarily the date of onset”).

With these principles in mind, and since Mr. Blankenship has established his entitlement to benefits on the basis of complicated pneumoconiosis, I must next evaluate the record and determine whether Mr. Blankenship had complicated pneumoconiosis prior to September 1996.

### Complicated Pneumoconiosis

The regulation, in part, at 20 C.F.R. § 718.304, provides that if a claimant is able to establish the presence of complicated pneumoconiosis, then an irrebuttable presumption of total disability due to pneumoconiosis is established. In the Black Lung Benefits Act, 30 U.S.C. 921 (c) (3) (A) and (C), as implemented by 20 C.F.R. § 718.304 (a), Congress determined that if a miner suffered from a chronic dust disease of the lung which “when diagnosed by chest X-ray, yields one or more large opacities (greater than one centimeter in diameter) and would be classified in category A, B, or C,” there shall be an irrebuttable presumption that his death was due to pneumoconiosis.<sup>11</sup> This type of large opacity is called “complicated pneumoconiosis.” Additional provisions of 20 C.F.R. §§ 718.304 also permit complicated pneumoconiosis to be established by either: (b) biopsy or autopsy findings of massive fibrosis; or, (c) other means

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<sup>11</sup>On the standard ILO chest x-ray classification worksheet, Form CM 933, large opacities are characterized by three sizes of opacities, identified by letters. The interpretation finding of Category A indicates the presence of a large opacity having a diameter greater than 10 mm (one centimeter) but not more than 50 mm; or several large opacities, each greater than 10 mm but the diameter of the aggregate does not exceed 50 mm. Category B mean an opacity, or opacities “larger or more numerous than Category A” whose combined area does not exceed the equivalent of the right upper zone of the lung. Category C represents one or more large opacities whose combined area exceeds the equivalent of the right upper zone.

which would be expected to produce equivalent results in chest x-rays or biopsy/autopsy evidence.

According to the U.S. Court of Appeals for the Fourth Circuit<sup>12</sup> in *Eastern Associated Coal Corp. v. Director, OWCP [Scarbro]*, 220 F.3d 250 (4th Cir. 2000), the existence of complicated pneumoconiosis is established by “congressionally defined criteria.” As a result, the statute’s definition of complicated pneumoconiosis as radiographic evidence of one or more large opacities categorized as size A, B, or C, 30 U.S.C. 921 (c) (3) (A), represents the most objective measure of the condition. This provision sets the benchmark by which other methods for proving complicated pneumoconiosis are measured, as described in 30 U.S.C. 921 (c) (3) (B) and (C). *Id.* at 256. In other words, whether a massive lesion or other diagnostic results represent complicated pneumoconiosis under 30 U.S.C. 921 (c) (3) (B) and (C) requires an equivalency evaluation with the x-ray criteria set forth in 30 U.S.C. 921 (c) (3) (A).<sup>13</sup> Additionally, the court emphasized that the legal definition of complicated pneumoconiosis as established by Congress controls over the medical community’s definition of the disease. *Id.* at 257. Finally, the court indicated that although all relevant and conflicting medical evidence must be considered and evaluated:

if the x-ray evidence vividly displays opacities exceeding one centimeter, its probative force is not reduced because the evidence under some other prong is inconclusive or less vivid. Instead, the x-ray evidence can lose force only if other evidence affirmatively shows that the opacities are not there or are not what they seem to be, perhaps because of an intervening pathology, some technical problem with equipment, or incompetence. *Id.*

In light of these statutory, regulatory and judicial principles, the adjudication of whether a claimant is able to invoke the irrebuttable presumption under 20 C.F.R. § 718.304 involves a two-step process. First, I must determine whether: a) the preponderance of the chest x-rays establishes the presence of large opacities characterized by size as Category A, B, or C under recognized standards; or b) biopsy or autopsy evidence or other diagnostic means discloses massive lesions which are equivalent to chest x-ray evidence of large opacities characterized as Category A, B, or C. At this stage of the process, the essential inquiry is whether such large opacities, or their equivalent, exist. Thus, as observed by the *Scarbro* court, definitive evidence indicating the large opacities are not really present would preclude invocation of the 20 C.F.R. § 718.304 presumption.

Second, if the preponderance of the evidence demonstrates the existence of large opacities, I must then consider all other relevant evidence to determine whether that evidence affirmatively shows the large opacities are not what they seem to be due to some other pathology.

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<sup>12</sup>Mr. Blankenship’s case arises within the jurisdiction of this court.

<sup>13</sup>See also 20 C.F.R. §§ 718.304 (b) and (c).

## *Existence of Large Opacities*

### Chest X-Rays

I must start the *Scarboro* adjudication process by evaluating chest x-ray imaging under 20 C.F.R. § 718.304 (a) to determine whether large opacities are present. During this evaluation, several important factors need to be considered. First, since the parties have stipulated that Mr. Blankenship had complicated pneumoconiosis by September 1996 and the issue before me is date of entitlement, my analysis will cover only the chest x-rays developed prior to that date.

Next, as Dr. Robinette has repeatedly emphasized, since the September 4, 1990 lobectomy removed a portion of Mr. Blankenship's left lower lobe, the immediate post-operative chest films would not be expected to contain a large opacity in the left lower lobe area (CX 3).

Dr. Robinette's observation also seems to suggest that the evaluation of the radiographic evidence should really be limited to chest film studies which pre-date the lung surgery. However, based more recent radiographic evidence, the Employer has stipulated that Mr. Blankenship developed complicated pneumoconiosis by September 1996. In light of that development, my analysis on the onset date of complicated pneumoconiosis requires reviewing radiographic evidence in the record up to September 1996.

Finally, under 20 C.F.R. § 718.304 (a), the radiographic standard for complicated pneumoconiosis requires the presence of an opacity greater than one centimeter (emphasis added). The regulation also requires that the chest x-ray meet the standards prescribed in 20 C.F.R. § 718.202, and in turn by subsequent references, 20 C.F.R. § 718.102, and Appendix A to Part 718. According to Appendix A, the chest x-ray used to diagnose pneumoconiosis "shall be a single postero-anterior projection at full inspiration." At the same time, the regulation provides that "[a]dditional chest x-rays or views shall be obtained if they are necessary for clarification and classification."

Date of x-ray	Exhibit	Physician	Interpretation
January 10, 1976	DX 25	(Sutherland Clinic)	Positive for pneumoconiosis, profusion category 1/1, <sup>14</sup> type p opacities; <sup>15</sup> no large opacities.

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<sup>14</sup>The profusion (quantity) of the opacities (opaque spots) throughout the lungs is measured by four categories: 0 = small opacities are absent or so few they do not reach a category 1; 1 = small opacities definitely present but few in number; 2 = small opacities numerous but normal lung markings are still visible; and, 3 = small opacities very numerous and normal lung markings are usually partly or totally obscured. An interpretation of category 1, 2, or 3 means there are opacities in the lung which may be used as evidence of pneumoconiosis. If the interpretation is 0, then the assessment is not evidence of pneumoconiosis. A physician will usually list the interpretation with two digits. The first digit is the final assessment; the second digit represents the category that the doctor also seriously considered. For example, a reading of 1/2 means the doctor's final determination is category 1 opacities but he considered placing the interpretation in category 2. Additionally, according to 20 C.F.R. § 718.102 (b), a profusion reading of 0/1 does not constitute evidence of pneumoconiosis.

<sup>15</sup>There are two general categories of small opacities defined by their shape: rounded and irregular. Within those categories the opacities are further defined by size. The round opacities are: type p (less than 1.5 millimeter (mm) in diameter), type q (1.5 to 3.0 mm), and type r (3.0 to 10.0 mm). The irregular opacities are: type s (less than 1.5

March 30, 1976	DX 25	(Sutherland Clinic)	Positive for pneumoconiosis, profusion category 1/1, type p opacities; no large opacities.
July 31, 1990	CX 3	Dr. Robinette, B <sup>16</sup>	Mild interstitial fibrosis, upper lobes.
(same)	EX 1 & DX 62	Dr. Wiot, BCR, B	Positive for pneumoconiosis, profusion category 1/1, type q opacities; no large opacities.
(same)	DX 63	Dr. Fino, B	Positive for pneumoconiosis, profusion category 1/0, type r opacities; no large opacities.
(same)	DX 59	Dr. Castle, B	Negative for pneumoconiosis, profusion category 0/1, type q/r opacities; no large opacities present; area of inflammation in left lower lobe.
August 21, 1990 (PA view)	CX 3	Dr. Epling	Reticulonodular densities apex bilaterally suggestive of chronic process, left lower lobe atelectasis.
(same)	EX 1 & DX 62	Dr. Wiot, BCR, B	Positive for pneumoconiosis, profusion category 1/1, type q/r opacities; no large opacities.
(same)	DX 63	Dr. Fino, B	Positive for pneumoconiosis, profusion category 1/0, type r opacities; no large opacities.
August 21, 1990 (Lateral View)	CX 3	Dr. Epling	Four centimeter lesion posterior lung base consistent with mass identified in 8/21/90 CT scan (which identified 4 x 3 centimeter mass in left lower lobe).
September 12, 1990	EX 1	Dr. Wiot, BCR, B	Positive for pneumoconiosis, profusion category 1/1, type q/r opacities; no large opacities.
(same)	DX 63	Dr. Fino, B	Positive for pneumoconiosis, profusion category 1/0, type r opacities; no large opacities.
October 12, 1990	CX 3	Dr. Robinette, B	Positive for pneumoconiosis, profusion category 1/1, type r/q opacities; no large opacities.
(same)	CX 3	Dr. Mullens	Nodular interstitial lung disease consistent with coal workers' pneumoconiosis.
(same)	DX 63	Dr. Fino, B	Positive for pneumoconiosis, profusion category 1/0, type r opacities; no large opacities.
(same)	DX 62	Dr. Wiot, BCR, B	Positive for pneumoconiosis, profusion category 1/1, type q opacities; no large opacities.
(same)	DX 50	Dr. Castle, B	Negative for pneumoconiosis, profusion category 0/1, type q/r opacities; no large opacities.
(same)	DX 50	Dr. Steward, B	Negative for pneumoconiosis, profusion category 0/1, type q/r opacities; no large opacities.
(same)	DX 50	Dr. Hippensteel, B	Negative for pneumoconiosis, profusion category 0/1, type r/q opacities; no large opacities.
(same)	DX 37	Dr. DePonte	Positive for pneumoconiosis, profusion category 1/1, type r/q opacities; no large opacities.
(same)	DX 37	Dr. Mathur, B	Positive for pneumoconiosis, profusion category 1/1, type q/r opacities; no large opacities.
(same)	DX 37	Dr. Robinette, B	Positive for pneumoconiosis, profusion category 1/1, type r/q opacities; no large opacities.

mm), type t (1.5 to 3.0 mm) and type u (3.0 to 10.0 mm). JOHN CRAFTON & ANDREW DOUGLAS, RESPIRATORY DISEASES 581 (3d ed. 1981).

<sup>16</sup>The following designations apply: B – B reader, and BCR – Board Certified Radiologist. These designations indicate qualifications a person may possess to interpret x-ray film. A “B Reader” has demonstrated proficiency in assessing and classifying chest x-ray evidence for pneumoconiosis by successful completion of an examination. A “Board Certified Radiologist” has been certified, after four years of study and examination, as proficient in interpreting x-ray films of all kinds including images of the lungs. *See also* 20 C.F.R. § 718.202 (a) (1) (ii).

June 11, 1991	DX 65	Dr. Wheeler, BCR, B	Negative for pneumoconiosis, profusion category 0/1, type q opacities, two centimeter mass compatible with infection disease or neoplasm.
(same)	DX 65	Dr. Scott, BCR, B	Positive for pneumoconiosis, profusion category 1/1, type q opacities, mass inferior right hilum.
(same)	DX 36	Dr. Shipley, BCR, B	Negative for pneumoconiosis.
(same)	DX 35	Dr. Wiot, BCR, B	Positive for pneumoconiosis, profusion category 1/1, type q opacities; no large opacities present.
(same)	DX 19 & 21	Dr. Sutherland	Positive for pneumoconiosis, profusion category 1/1, type p/q opacities; emphysema; no large opacities present.
July 31, 1991	DX 65	Dr. Wheeler, BCR, B	Negative for pneumoconiosis, profusion category 0/1, type q opacities, two centimeter mass lower right hilum and one centimeter mass left mid lung, compatible with infection disease or neoplasm.
(same)	DX 65	Dr. Scott, BCR, B	Positive for pneumoconiosis, profusion category 1/1, type q opacities, possible mass right hilum.
(same)	DX 20	Dr. Sutherland	Positive for pneumoconiosis, profusion category 2/3, type p/q opacities; no large opacities.
(same)	DX 18	Dr. Navani, BCR, B	Positive for pneumoconiosis, profusion category 1/1, type r/q opacities; Category A, 1.1 centimeter pulmonary nodule left mid zone.
April 13, 1992	DX 37	Dr. Sargent, B	Positive for pneumoconiosis, profusion category 1/1, type r opacities; no large opacities present.

Based on the above summary, I first note that the preponderance of the radiographic evidence from 1976 through July 31, 1990 does not establish the presence of a large pulmonary opacity.

Next, since only one of the five post-operative chest x-rays shows the presence of a large opacity, the preponderance of the post-operative radiographic evidence between September 4, 1990 and April 13, 1992 is insufficient to establish the presence of a large pulmonary nodule. Specifically, concerning the July 31, 1991 chest x-ray, although Dr. Sutherland did not observe a large opacity and Dr. Scott didn't provide the measurements for the "possible" pulmonary mass he noted, both Dr. Wheeler and Dr. Navani, who were B readers and board certified radiologists, observed a large opacity. Dr. Wheeler found a two centimeters pulmonary mass.<sup>17</sup> Dr. Navani measured the opacity at 1.1 centimeters and characterized it as a Category A opacity. Based on their consensus that a mass greater than one centimeter was present, I find the July 31, 1991 chest x-ray is positive for a large opacity. However, none of the physicians to examine the remaining four chest x-rays of, September 12, 1990, October 12, 1990, and June 11, 1991 found evidence of a large opacity. Additionally, Dr. Sargent's sole interpretation of the April 13, 1992 film establishes that this last chest x-ray is negative for a large opacity.

Finally, I turn to the two chest x-rays of August 21, 1990. For most of this claim's extensive litigation, almost all of the physicians, with the exception of Dr. Robinette and Dr.

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<sup>17</sup>I recognize that Dr. Wheeler did not believe the two centimeter mass was related to pneumoconiosis. However, at the stage of the *Scarboro* analysis my concern is whether a large opacity is observable. Dr. Wheeler indicates such an opacity was present.

Epling, have focused on the postero-anterior (“PA”) image from that date to conclude no pre-operative chest x-ray image of a large opacity was present. For example, during his April 1993 deposition (DX 62), when he indicated that no radiographic image of an opacity greater than one centimeter appeared in the pre-operative chest x-rays, Dr. Wiot specifically again reviewed this film and discussed it in terms of a PA image.

Yet, during my review of the evidence, and as previously stressed by Dr. Robinette and eventually relied upon by Judge Avery, a second August 21, chest x-ray, taken laterally and interpreted by Dr. Epling, established the presence of a four centimeter mass (CX 3).<sup>18</sup> At first, this solitary radiographic image of a large opacity seems to be overwhelmed by the negative interpretation of the PA image. None of the three physicians, including Dr. Epling, who evaluated the August 21, 1990 PA chest x-ray observed a large opacity. At best, Dr. Wiot noted some inflammatory “changes” behind the heart. However, Dr. Robinette explained that the four centimeter radiographic mass observed in the lateral film was located in the left lower lobe and obscured by the shadow of the heart on the PA chest x-ray. Notably, Dr. Castle agreed that such an opacity might be hidden by the heart’s outline. Thus, in light of Dr. Robinette’s reasonable and essentially unchallenged explanation and in the absence of any contrary interpretation of the lateral chest x-ray of August 21, 1990, I conclude the August 21 1990 lateral chest x-ray is more probative than the PA image concerning the left lower lobe mass and establishes the requisite radiographic mass greater than one centimeter under the provisions of 20 C.F.R. § 718.304.

I have considered whether technical equipment difficulties or interpretative incompetence might be responsible for the lateral chest x-ray interpretation of a large opacity, such that the image was false and the four centimeter mass was not really there. In that regard, some of the pathology findings suggest the large mass might not be there. In particular, Dr. Hansbarger concluded that the 1.3 centimeter mass he observed during the biopsy would not appear as an opacity greater than one centimeter. However, in making his equivalency estimate, Dr. Hansbarger only focused only his biopsy finding and did not specifically address Dr. Epling’s interpretation of the lateral chest x-ray or the corresponding CT scan findings from the same day.

Despite Dr. Hansbarger’s estimation, any controversy about the radiographic presence of the large opacity on August 21, 1990 lateral chest x-ray seems to be resolved by the contemporaneous CT scan which established the presence of a large, 4 x 3 centimeter mass in the left lower lobe, the same area that Dr. Robinette indicated was behind the heart’s shadow. The CT scan provides significant corroboration for Dr. Epling’s finding of the four centimeter opacity on the August 21, 1990 lateral chest x-ray. Notably, this August 21, 1990 CT scan has been extensively reviewed by many medical experts in this case. While those physicians have provided varying opinions of what the CT scan mass might be, none of the doctors directly challenged Dr. Epling’s CT scan finding of a 4 x 3 centimeter mass. Even Dr. Wiot, who found

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<sup>18</sup>In its most recent decision, the Benefits Review Board dismissed the Employer’s objections to the admissibility of Dr. Robinette’s assessment based on the lateral chest x-ray interpretation due to quality standards and access concerns. In particular, the Board concluded that that several of the physicians utilized by the Employer had access to the August 21, 1990 films. Additionally, the record in this case for many years has contained Dr. Robinette’s extensive treatment notes and his comments, which included his specific reference to the August 1990 lateral chest x-ray interpretation. Finally, in the hearing before me, the Employer raised no objection to the admissibility of CX 3, which contained the hospital records from August and September 1990, including Dr. Epling’s two radiographic interpretations from August 21, 1990.

no opacity greater than one centimeter in the PA chest film, noted the presence of a 4 x 3 centimeter mass in the CT scan. Finally, and significantly, in presenting his equivalency assessment, Dr. Hansbarger likewise did not challenge the accuracy of the August 21, 1990 CT scan imaging or attempt any reconciliation of his pathology equivalency determination with the actual radiographic images. Accordingly, I find Dr. Epling's lateral chest x-ray interpretation was accurate and establishes the presence of a large radiographic opacity greater than one centimeter.

### *Other Medical Evidence*

Since Mr. Blankenship has proven the existence of a radiographic opacity greater than one centimeter was present in his lungs in August 1990, my determination on the date of entitlement requires that I move to the second adjudicative step added by the court in *Scarboro* and consider other relevant medical evidence prior to making a determination whether Mr. Blankenship had complicated pneumoconiosis in August 1990 under 20 C.F.R. § 718.304.

According to the *Scarboro* court, in this second stage of the analysis, I must determine whether the preponderance of the other medical evidence affirmatively shows that the August 21, 1990 large opacity was not what it appears to be or was caused by some intervening pathology other than coal dust exposure or coal workers' pneumoconiosis. In Mr. Blankenship's case, the "other" medical evidence has three components: 1) hospitalization records; 2) biopsy findings and 3) medical opinions

#### 1. Hospitalization Records (CX 3)

In August 1990, Mr. Blankenship was referred to Dr. Robinette for evaluation of a persistent, choking cough. An August 21, 1990 chest CT scan showed a 4 x 3 centimeter mass in the lower left lung, which might be lung carcinoma. The study also revealed 1.5 and 2.0 centimeter lymph nodes. Dr. Epling reported that in chest x-rays taken the same day, reticulonodular densities were present bilaterally in the lung apices, "suggestive of a chronic disease." In a lateral view only, Dr. Epling noted a "4 cm lesion, posterior lung base consistent with mass demonstrated on thoracic CT scan of 8-21-90."

When subsequent bronchial washings and a fine needle biopsy produced inconclusive results, an exploratory thoracotomy and resection of the left lower lung lobe was accomplished on September 4, 1990. The pathology report indicated the presence of anthracotic pneumoconiosis with massive fibrosis and focal emphysema. Lab tests for tuberculosis and cancer were negative. Mr. Blankenship was discharged from the hospital on September 12, 1990.

### Discussion

Through a progressive series of medical analytical procedures, several possible causes of the pulmonary mass, including cancer and tuberculosis, were eliminated as etiologies. Eventually, the lung resection and following pathology examination identified the presence of

pneumoconiosis which certainly supports rather than refutes a conclusion that the radiographic pulmonary mass was related to Mr. Blankenship's coal mine employment.

## 2. Biopsy Findings<sup>19</sup>

Prior to reviewing the diverse biopsy reports concerning Mr. Blankenship's lung tissue, a review of the regulatory provisions on the requisite standard for diagnosing pneumoconiosis based on biopsy helps to understand the significance of some of the reports. The regulations define "clinical" pneumoconiosis as a condition characterized by permanent deposition of substantial amounts of particulate matter, caused by coal dust exposure, in the lungs **and** "the fibrotic reaction of the lung tissue to that deposition." 20 C.F.R. § 718.201 (a) (emphasis added). As a result, an autopsy or biopsy finding of anthracotic pigmentation, standing alone, is not sufficient to establish the presence of pneumoconiosis, 20 C.F.R. § 718.202 (a) (2). Additionally, a diagnosis of a "chronic lung disease" (complicated pneumoconiosis) may be established if a biopsy or autopsy reveals the presence of massive lesions. 20 C.F.R. § 718.304.

Dr. J. W. Ferguson  
(DX 46, DX 199, and DX 210)

On September 6, 1990, Dr. Ferguson, board certified in anatomic and general pathology, received several specimens from Mr. Blankenship's September 4, 1990 lung operation. One specimen came from the left lower lobe of Mr. Blankenship's lungs and measured 14 by 9 by 4.5 centimeters. Upon gross examination, Dr. Ferguson found a "markedly thickened and fibrotic" pleura. The "subadjacent" pulmonary tissue was "markedly anthracotic and atelectatic"<sup>20</sup>. Under the microscope, Dr. Ferguson observed: a) anthracotic lymph nodes, b) many areas of anthracotic pigment associated with "disruption of the surrounding alveoli with secondary emphysematous changes," c) multiple small anthracotic fibrous nodules; and, d) "one area" of "irregular hyaline scar tissue" extending from the pleura into the underlying lung tissue, containing at times dense anthracotic pigment and forming "a mass measuring approximately 2 x 3 cm in greatest dimension." Based on his examination, Dr. Ferguson diagnosed anthrasicotic pneumoconiosis with massive fibrosis and focal emphysema.

In an April 2003 deposition, Dr. Ferguson discussed the size of the massive fibrosis. He stated:

The area in question is basically when you have multiple pieces of a mass and you're trying to estimate the size from the slides, you try to look for the maximal dimensions in a couple of areas and then you take into account that there is going to be some tissue shrinkage on the slide and you would kind of extrapolate that into the estimate of the size of the lesion. And from doing that, I estimated the size of the lesion measured two to three centimeters in greatest dimension.

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<sup>19</sup>On January 28, 2004, Dr. Richard Buddington advised that the lung specimen slides had been destroyed in accordance with established pathology guidelines.

<sup>20</sup>Collapsed. DORLAND'S ILLUSTRATED MEDICAL DICTIONARY 154 (28th ed. 1994).

Dr. Ferguson also opined that such a two to three centimeter mass would show up on a chest x-ray as a one centimeter shadow.

Dr. Echols A. Hansbarger  
(DX 40 and DX 60)

On April 30, 1992, Dr. Hansbarger evaluated Mr. Blankenship's lung biopsy slides. In the lung specimen, Dr. Hansbarger noted dense fibrotic reaction with numerous deposits of anthracotic pigment and reactive fibrosis. Individual coal macules measured up to 0.3 centimeters. He reported "other nodules are noted which are larger and contain a central core of fibrosis with surrounding pigment." Further, one area of conglomeration measured 1.3 centimeters in its greatest dimension. Dr. Hansbarger diagnosed moderately severe pulmonary anthracosis of the left lower lobe. Additionally, having reviewed Dr. Ferguson's biopsy report, Dr. Hansbarger disagreed with his diagnosis of massive fibrosis since none of the pulmonary nodules were greater than 2 centimeters.

In an April 14, 1993 deposition, Dr. Hansbarger reasserted his diagnosis of simple coal workers' pneumoconiosis based on the presence of several coal macules measuring up to 0.3 centimeters. Although several of the nodules were grouped together and measured 1.3 centimeter, the mass was "not a solid area, but just a group of coal macules that were grouped together." No single macule was greater than one centimeter in size. According to Dr. Hansbarger, a diagnosis of progressive massive fibrosis, which is a "very uncommon disease," requires that the pulmonary mass be solid and greater than two centimeters in size. He also commented that normal clinical findings would cause him to "think that complicated pneumoconiosis is not present."

Dr. Emory H. Robinette, Jr.  
(DX 67)

As part of his treatment of Mr. Blankenship in the late summer of 1990, Dr. Robinette, board certified in pulmonary disease and internal medicine, reviewed the lung pathology slides.<sup>21</sup> In the lung specimen slide, he observed "an area of progressive massive fibrosis" and was relieved to discover it was not cancer.

#### Discussion

The respective methodologies and apparently disparate findings of the two pathology experts, Dr. Ferguson and Dr. Hansbarger, have provided the fuel for a fifteen year legal dispute. Dr. Ferguson's findings of 2 times 3 centimeter anthracotic mass and his diagnosis of massive fibrosis support a diagnosis of complicated pneumoconiosis. Dr. Hansbarger reached a contrary conclusion based on his examination of the lung tissue sample. At this step of the adjudicative process, this standoff between two similarly well qualified pathologists simply means the biopsy

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<sup>21</sup>When Dr. Robinette discussed his microscopic review in the April 20, 1993, he described the pulmonary mass as a 14 x 9 x 4.5 centimeter "lesion." Later, in October 1999, Dr. Robinette explained those dimensions referred to the size of the biopsy lung specimen rather than a mass of complicated pneumoconiosis.

evidence appears inconclusive as to whether the accumulated coal dust macules are really complicated pneumoconiosis. Arguably, Dr. Robinette's pathology finding of progressive massive fibrosis tips the balance towards a biopsy diagnosis of complicated pneumoconiosis.

Concerning an intervening pathology, a notable commonality among the opinions of the two pathologists and Dr. Robinette is their microscopic observations of anthracotic macules and associated fibrosis. That similarity in the pathology studies definitively identifies coal dust exposure, rather than some other non-coal mine employment pulmonary hazard, as at least one cause of the pulmonary mass. Consequently, the biopsy findings support rather than negate an etiology conclusion that the large radiographic opacity is related to Mr. Blankenship's coal mine employment.

### 3. Medical Opinions<sup>22</sup>

Dr. Emory H. Robinette, Jr.  
(DX 52, DX 67, DX 128, DX 182, DX 188, CX 2, and CX 3)

In the summer of 1990, based on a referral from Dr. Sutherland, Dr. Robinette, a board certified pulmonary physician, evaluated Mr. Blankenship for a cough and increasing respiratory difficulties. Due to a radiographic mass and since a fine needle biopsy and bronchial washings were not definitive, Mr. Blankenship underwent lung surgery and the removal of a portion of his left lower lobe. Pathological review indicated the presence of complicated pneumoconiosis rather than cancer. From August of 1990 through April 2004, Dr. Robinette continued to follow Mr. Blankenship's pulmonary condition through office visits which averaged three times a year.

In the April 20, 1993 hearing, Dr. Robinette again discussed his treatment of Mr. Blankenship and his diagnosis of complicated pneumoconiosis. Dr. Robinette explained the pulmonary mass "was not visible in the plane chest x-ray because it was retrocardiac." In other words, in the AP chest x-ray, the "heart silhouette just blocked out the opacity" that would be seen. When the CT scan revealed the retrocardiac mass, Dr. Robinette thought it might be cancer due to its size of 4 x 5 centimeters. Dr. Robinette also reviewed both pathology reports and noted Dr. Ferguson's finding of a 2 x 3 centimeter mass. He also commented that complicated pneumoconiosis usually develops in a background of coal workers' pneumoconiosis which was also present in Mr. Blankenship's case. Dr. Robinette based his complicated pneumoconiosis diagnosis on the radiographic images coupled with the microscopic examination of the lung specimen.

In December 1996, Dr. Robinette explained that a lobectomy was performed because an earlier 1987 CT scan had failed to disclose any evidence of the mass discovered in the 1990 CT scan. He again emphasized that a pulmonary mass was observed on the lateral chest x-ray which was not present on the PA chest film.

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<sup>22</sup>Dr. Sutherland conducted a pulmonary evaluation in June 1991 but did not specifically address whether Mr. Blankenship had complicated pneumoconiosis in August 1990. Instead, he concluded Mr. Blankenship was totally disabled due to the subsequent lung surgery (DX 15 and DX 16).

In October 1999, in response to a question whether the 1.3 cm biopsy mass would appear as a one centimeter mass on a chest x-ray, Dr. Robinette stated that the CT scan showed the presence of a 5 x 4 centimeter pulmonary mass, which “was not as well seen” on the PA chest x-ray. A corresponding lateral chest x-ray revealed a 4 centimeter “density that was retrocardiac and obscured by the heart border.” “The radiographic presentation was clearly connected with a Category A mass.” When the lung biopsy specimen was examined, multiple anthracotic nodules were noted, measuring up to 20 x 10 mm. According to Dr. Robinette, “Mr. Blankenship clearly had a lesion consistent with progressive massive fibrosis with an area of fibrotic lung disease surrounding a relatively large pulmonary nodule.” He added, “despite the pathological argument that this largest opacity was 1.4 cm. in size, there were multiple opacities present contributing to the large 4 cm. mass effect.” Significantly, the subsequent, post-surgery, development of another large pulmonary mass demonstrated the progressive nature of Mr. Blankenship’s lung disease.

Following an August 2001 office evaluation of Mr. Blankenship, Dr. Robinette discussed his diagnosis of complicated pneumoconiosis in 1990. At that time, Mr. Blankenship had complicated pneumoconiosis based on radiographic evidence of a 5 x 4 centimeter mass and biopsy evidence of fibrotic lung disease. Concerning Dr. Hansbarger’s pathology report, Dr. Robinette comment:

Although the pathologist was only able to document a lesion of approximately 1.3 cm. in size, the surrounding tissue would have accounted for the 4 cm radiographic abnormality. The surrounding tissue was clearly involved with mass distortion and a fibrotic reaction.

In a May 14, 2002 deposition, Dr. Robinette recounted that the September 1990 surgery involved the removal of an entire segment of the left lower lobe “which was involved with the large anthracotic mass.” Having reviewed the pathology slides, Dr. Robinette agreed with Dr. Ferguson’s findings rather than Dr. Hansbarger’s observations. In terms of radiographic equivalency, the biopsy lesion of progressive massive fibrosis was greater than two centimeters and it actually measured four centimeter in the lateral chest x-ray. In other words, the pathology mass would measure, and actually did measure, greater than one centimeter on a chest x-ray. Dr. Robinette once again stressed, “the mass density in his chest was four centimeters times three centimeters in size and it was associated with some linear stranding and scarring. That’s a large spot that’s almost a Category B mass by technical definition, not just Category A.”

Dr. J. Dale Sargent  
(DX 37, DX. 61, and DX 63)

In April 1992, Dr. Sargent, board certified in pulmonary and internal medicine, evaluated Mr. Blankenship’s pulmonary condition. A chest x-ray and CT scan indicated that Mr. Blankenship had coal workers’ pneumoconiosis. However, because the pulmonary function test and arterial blood gas studies were normal, Dr. Sargent concluded Mr. Blankenship was not totally disabled. Responding to Mr. Blankenship’s representation that he had lung surgery in 1990, Dr. Sargent stated, “if his lung biopsy did indeed show a conglomerate lesion of coal workers’ pneumoconiosis, then a diagnosis of complicated pneumoconiosis must be made.”

In March 1993, Dr. Sargent also reviewed earlier chest x-rays, pulmonary examinations, and the pathology reports. Based on this review, Dr. Sargent opined that Mr. Blankenship only had simple coal workers' pneumoconiosis because there was no radiographic evidence of a pulmonary nodule greater than one centimeter. Since the pulmonary tests were normal, Mr. Blankenship was not totally disabled.

In April 1993 deposition, Dr. Sargent stated Mr. Blankenship did not have complicated pneumoconiosis for three reasons. First, progressive massive fibrosis only occurs "within a background of rather severe simple pneumoconiosis"; whereas, Mr. Blankenship's pneumoconiosis profusion was low. Second, the radiographic abnormality in the left lower lobe "is not a place that's noted to develop progressive massive fibrosis." Third, Dr. Ferguson's report only describes simple pneumoconiosis with a scar in the lung tissue rather than a large conglomerate lesion and progressive massive fibrosis. Thus, although "there was a nodule in excess of one centimeter. . .it was in the wrong place and not associated with the appropriate background changes to call it progressive massive fibrosis."

Dr. Gregory J. Fino  
(DX 63)

In March 1993, Dr. Fino, board certified in pulmonary disease and internal medicine, reviewed the radiographic and medical record.<sup>23</sup> Based on his evaluation, Dr. Fino concluded Mr. Blankenship did not have complicated pneumoconiosis. He did not find any mass in the chest x-rays or CT scans that was suggestive of complicated pneumoconiosis. Additionally, Mr. Blankenship had normal pulmonary functions. Although not a pathologist and thus not in a position to directly challenge Dr. Ferguson, Dr. Fino nevertheless observed that "the abnormalities at lung biopsy should correlate, if they are true, with any changes seen clinically." Notably, Mr. Blankenship had "no clinical changes consistent with complicated coal workers' pneumoconiosis."

Dr. James R. Castle  
(DX 59, DX 64, DX 67, and DX 198)

In March 1993, Dr. Castle, board certified in pulmonary and internal medicine, evaluated the medical record. Dr. Castle concluded Mr. Blankenship only had simple coal workers' pneumoconiosis, without total disability. He also stated that the radiographic evidence did not support a finding of complicated pneumoconiosis.<sup>24</sup>

In an April 14, 1993 deposition, Dr. Castle indicated the pathology report, particularly Dr. Hansbarger's assessment established that Mr. Blankenship had simple coal workers' pneumoconiosis. He noted that an August 1990 CT scan indicated an abnormality but its location in the left lower lobe was not consistent with complicated pneumoconiosis. Instead, the CT scan "appears to be more of an inflammatory process" due to infection.

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<sup>23</sup>Dr. Fino also conducted a pulmonary evaluation in November 2002 and continued to find no evidence of total disability or complicated pneumoconiosis (DX 198).

<sup>24</sup>In preparing his report, Dr. Castle only reviewed the pre-operative chest x-ray reports developed in 1976.

In testimony at the April 20, 1993 hearing, having reviewed additional chest x-rays and medical reports, Dr. Castle provided further explanation for his conclusions. According to Dr. Castle, in terms of radiographic evidence, Mr. Blankenship did not have complicated pneumoconiosis. While Dr. Castle observed an abnormality in the chest x-ray, he saw no evidence of complicated pneumoconiosis. At the same time, he agreed that if the mass was behind the heart shadow, it would be difficult to see. The CT scan showed a "process" in the left lower lung that didn't look like complicated pneumoconiosis because it was not "solid." The process may have been due to a bacterial infectious process. Although Mr. Blankenship's medical "records. . . did not indicate that there was a problem with an infection in the past," Mr. Blankenship had reported a lung problem four years earlier which could have possibly involved a pulmonary infection. He agrees with diagnoses of Dr. Wiot, Dr. Hansbarger, and Dr. Sargent.

Pathologically, the mass discovered during the biopsy was not complicated pneumoconiosis because it did not represent "total obliteration of the lung airways, blood vessels, and so forth." Dr. Castle also doubted that Dr. Ferguson's observation of a 2 x 3 centimeter mass was an "actual measured nodule of that size" because the pathologist used the term "mass" and noted an area consisting of "multiple small separate nodules." Additionally, the mass' location was atypical because complicated pneumoconiosis is usually located in the "apical segments of the upper lobes." Further, complicated pneumoconiosis is usually found in a background of profusion category 2 or 3 coal workers' pneumoconiosis. It was "very uncommon" to see progressive massive fibrosis in a patient with only profusion category 1 coal workers' pneumoconiosis. Dr. Castle acknowledged that "alveolar coalescence can" lead to pulmonary massive fibrosis. Finally, while most people with complicated pneumoconiosis have abnormal pulmonary functions, Mr. Blankenship's pulmonary tests are remarkably normal.

In a November 2002 medical record review, Dr. Castle again discussed the evidence concerning the August 1990 lesion. Dr. Castle believed the chest x-ray image did not show a single lesion; instead, the image was due to nodules overlapping "each other and even partially fused." Dr. Castle also opined that the 1.3 centimeter pathology mass would not be seen as a 1.0 centimeter or large opacity on a chest x-ray.

Dr. Jerome Wiot  
(DX 62)

In an April 1993 deposition, having reviewed other radiologists' interpretations and the pathology reports, Dr. Wiot, a board certified radiologist, discussed his interpretations of the June and August 1990 x-rays of Mr. Blankenship's chest. Both films showed the presence of simple coal workers' pneumoconiosis in the upper lobes but no opacity greater than one centimeter. Dr. Wiot also observed "changes" in the "the base of his lung left lung. . . behind his heart" which were "residual of past inflammatory process" and a combination of "pleural disease, bronchiectasis, and linear fibrotic stranding." Dr. Wiot also reviewed the August 21, 1990 CT scan report which confirmed the presence of simple coal workers' pneumoconiosis in the upper lobes and the "changes" in the left lower lobe. Most often bacterial infection causes such changes. The CT scan "better demonstrated the structure of this process within the lower lung field" which included a 4 x 3 centimeter mass which was an "old inflammatory change."

Using the radiographic standard of an opacity greater than one centimeter attributable to coal dust exposure, Dr. Wiot found no evidence of complicated pneumoconiosis. He saw no evidence of coalescence in the films.

Dr. Richard L. Naeye  
(DX 129)

In August 1999, Dr. Naeye, board certified in anatomic and clinical pathology, reviewed the medical record, including the radiographic evidence and the pathology findings by Dr. Ferguson and Dr. Hansbarger. Dr. Naeye opined that Mr. Blankenship did not have complicated pneumoconiosis in 1990. He explained that complicated pneumoconiosis was a “rare” disorder which advances and further destroys normal lung tissue as long as the miner or ex-miner lives. The process destroys blood vessels at its edge, causing necrosis in the center. The pathology evaluations did not find necrosis in Mr. Blankenship’s lung specimen and if the lesions had remained in his lungs, “they would not have expanded as long as he did not resume mining coal.” The chest x-ray evidence revealed not a single lesion but “several smaller lesions in close proximity which touched each other and even partially fused at some points.” In other words, Mr. Blankenship:

Had a lesion which was comprised of several adjacent anthracotic micronodules which were adjacent to each other and formed a conglomerate mass on x-ray which reached 1 mm in diameter. Under the microscope, these partially coalesced lesions were of course much larger, reaching 1.3 cm in their out dimension.

At the same time, Dr. Naeye acknowledged that if only radiographic evidence were available, then “the law” might consider them evidence complicated pneumoconiosis. He believed the actual nature of the lesions determined through pathology study should be the controlling factor.

Dr. Joshua A. Perper  
(CX 1)

In February 2004, Dr. Perper, board certified in anatomical and clinical pathology, conducted an extensive review of the medical evidence in this case. In his opinion, Mr. Blankenship had complicated pneumoconiosis in 1990. Dr. Perper noted that after Mr. Blankenship presented to Dr. Robinette with increasingly difficult breathing problems in August 1990, a diagnostic CT scan showed the presence of a large, 5 x 4 centimeter mass in the lower left lung which was suspected to be cancer. The subsequent lung biopsy of the left lower lobe disclosed marked fibro-anthracotic thickening, a 6 x 5 centimeter nodule, and 20 x 10 millimeter enlarged lymph nodes. When the 6 x 5 centimeter area was dissected and microscopically examined, the pathologist found a 2 x 3 centimeter mass. While recognizing that Dr. Hansbarger only found masses up to 1.3 centimeters, Dr. Perper opined that Dr. Hansbarger had failed to reconcile his determination with notations of other large masses in the pathology report.

## Discussion

The multitude of medical opinions has understandable generated a wide range of assessments on the issue of whether Mr. Blankenship had complicated pneumoconiosis in August 1990. For different reasons, Dr. Hansbarger, Dr. Sargent, Dr. Fino, Dr. Naeye, Dr. Castle, Dr. Wiot opined that Mr. Blankenship did not have complicated pneumoconiosis. In contrast, Dr. Ferguson, Dr. Perper, and Dr. Robinette believe the radiographic and biopsy evidence from August 1990 established the presence of complicated pneumoconiosis. Due to this professional agreement, I must assess the relative probative weight of their opinions on the basis of documentation and reasoning.

As to the first factor, a physician's medical opinion is likely to be more comprehensive and probative if it is based on extensive objective medical documentation such as radiographic tests and physical examinations. *Hoffman v. B & G Construction Co.*, 8 B.L.R. 1-65 (1985). In other words, a doctor who considers an array of medical documentation that is both long (involving comprehensive testing) and deep (includes both the most recent medical information and past medical tests) is in a better position to present a more probative assessment than the physician who bases a diagnosis on a test or two and one encounter.

The second factor affecting relative probative value, reasoning, involves an evaluation of the connections a physician makes based on the documentation before him or her. A doctor's reasoning that is both supported by objective medical tests and consistent with all the documentation in the record, is entitled to greater probative weight. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19 (1987). Additionally, to be considered well reasoned, the physician's conclusion must be stated without equivocation or vagueness. *Justice v. Island Creek Coal Co.*, 11 B.L.R. 1-91 (1988).

With these principles in mind, and concluding that almost all the physicians had a firm documentary foundation, I first note, and as previously discussed, that Dr. Ferguson's pathology report supports a diagnosis of complicated pneumoconiosis considering the 2 x 3 centimeter anthracotic mass and his specific finding of massive fibrosis. In addition, Dr. Ferguson did not suggest any other cause for the pulmonary mass other than coal dust.

Dr. Hansbarger's opinion likewise does not isolate some other pulmonary hazard as the cause of the pulmonary nodules. Instead, Dr. Hansbarger found "dense" fibrotic reaction and diagnosed moderately severe coal workers' pneumoconiosis, which hardly represents evidence of other non-coal mine dust related cause for the mass.

Dr. Hansbarger believed Mr. Blankenship did not have complicated pneumoconiosis because the largest biopsy lesion was only 1.3 centimeters, which was well below the 2 centimeter pathology benchmark that he required to diagnose complicated pneumoconiosis. Although Dr. Hansbarger may or may not have sound medical grounds for his conclusion, the statute and regulation do not impose a two centimeter biopsy threshold. Finally, Dr. Hansbarger also indicated that Mr. Blankenship's normal clinical symptoms would suggest that he did not have complicated pneumoconiosis. However, the statutory and regulatory definition of complicated pneumoconiosis does not include clinical symptoms of total disability. Instead,

Congress defined the disease in terms of radiographic opacities and massive fibrosis. Although clinical symptoms would be relevant in identifying some other cause for the pulmonary mass, Dr. Hansbarger solely referenced the absence of total disability to support his conclusion complicated pneumoconiosis was not present. Thus, Dr. Hansbarger's sole disagreement is characterization as to the type of pneumoconiosis, not its source.

Similarly, the assessment of Dr. Sargent does not suggest some other cause for the pulmonary mass in Mr. Blankenship left lower lung lobe, other than coal dust exposure. Further, his conclusion that Mr. Blankenship did not have complicated pneumoconiosis is not well reasoned. Dr. Sargent based his conclusion that Mr. Blankenship did not have complicated pneumoconiosis on the absence of a background of severe simple pneumoconiosis and the location of the mass in the left lower lobe. However, while possibly on sound medical footing, Dr. Sargent failed to reconcile his statement with the pathology findings of Dr. Ferguson and Dr. Hansbarger of moderately severe coal workers' pneumoconiosis in the mass obtained from Mr. Blankenship's left lower lobe.

Next, Dr. Fino's conclusion does not identify an alternative cause for the large pulmonary mass. Having diagnosed simple coal workers' pneumoconiosis, he mainly disagreed with the complicated pneumoconiosis diagnosis because he did not see radiographic or CT evidence of a pulmonary mass consistent with complicated pneumoconiosis. However, Dr. Fino did not describe the factors he used to eliminate the large mass in the CT scan and lateral chest x-ray as complicated pneumoconiosis. Additionally, applying criteria not contained in the statute or regulation, Dr. Fino also highlighted the absence of clinical changes in terms of disability that he would expect to see with complicated pneumoconiosis.

Dr. Naeye presented a seemingly sound explanation for his conclusion Mr. Blankenship did not have complicated pneumoconiosis. Yet, as previously discussed by Judge Avery, Dr. Naeye's assessment has diminished probative value because he based his differentiating diagnosis on a narrow medical definition of complicated pneumoconiosis. Since the biopsy did not produce evidence of the typical necrosis associated with complicated pneumoconiosis, Mr. Blankenship did not have that "rare" disorder. As previously discussed, the legal standard for complicated pneumoconiosis does not require additional medical characteristics required by Dr. Naeye. Additionally, Dr. Naeye also did not explain why he found Dr. Hansbarger's estimate of 1.3 centimeter for the pulmonary mass more probative than Dr. Ferguson's 2 x 3 centimeter finding. Finally, Dr. Naeye's analysis did not suggest some other cause for the pulmonary fibrosis in the left lower lobe.

Through course of years, Dr. Castle has extensively reviewed the medical evidence and provided extensive explanation for his conclusion that Mr. Blankenship does not have complicated pneumoconiosis. Despite this in-depth familiarity with this case, Dr. Castle's assessment has diminished probative value because he used discriminating factors to eliminate complicated pneumoconiosis as a diagnosis which I have previously discussed as being problematic. Specifically, Dr. Castle stressed the absence of clinical total disability, location of the pulmonary mass in an area inconsistent with complicated pneumoconiosis, the absence of severe simple coal workers' pneumoconiosis and the absence of total obliteration of lung tissue.

Doubting the accuracy of Dr. Ferguson's measurement and relying on Dr. Hansbarger's report, Dr. Castle also emphasized that no nodule was greater than 1.3 centimeter, such that none would not appear as a chest x-ray opacity greater than one centimeter. Correspondingly, he opined that the mass identified in the CT scan represented several pulmonary nodules overlapping or fused together rather than a solid lesion of complicated pneumoconiosis. In presenting this conclusion, Dr. Castle did not explain why such fused nodules would not represent massive fibrosis as diagnosed by Dr. Ferguson. Additionally, Dr. Castle's nodule explanation does not present another etiology since both pathology reports link coal dust exposure to the nodules.

Finally, after concluding that the pulmonary mass was not complicated pneumoconiosis, Dr. Castle suggested that the "changes" in the left lower lobe in August 1990 might be attributable to a bacterial inflammatory process. Interestingly, in presenting his alternative etiology diagnosis, Dr. Castle did not reconcile his opinion with the pathology findings of Dr. Ferguson and Dr. Hansbarger. Notably, when they examined the lung specimen containing the "changes," neither pathologist presented a diagnosis suggestive of a bacterial infection. Instead, both pathologists found extensive evidence of anthracosis. Although he acknowledged the medical record did not contain any evidence of a bacterial infection, Dr. Castle nevertheless observed that Mr. Blankenship's report of a pulmonary problem four years earlier may have been a pulmonary infection. Dr. Castle's conjecture on that matter is speculative and does not support a diagnosis of bacterial pulmonary infection.

Dr. Wiot also attributed the 4 x 3 centimeter CT scan mass in part to "old inflammatory change." He believed the left lower lung "changes" consisted of pleural disease, residual inflammatory damage, linear fibrotic stranding. Dr. Wiot's reasoning on the inflammation diagnosis suffers the same deficiencies as Dr. Castle's opinion. Dr. Wiot did not indicate the portions of the pathology reports that showed the presence of residual inflammation. Likewise, he did not reference any evidence of bacterial pulmonary infection in the medical record.

Dr. Perper's analysis does not suggest some non-coal dust related etiology was responsible for the left lower lung mass in August 1990. At the same time, his conclusion that Mr. Blankenship had complicated pneumoconiosis has diminished probative value because he did not explain why he found Dr. Ferguson's pathology report analysis to be more probative than Dr. Hansbarger's analysis.

Finally, I believe Dr. Robinette presented the best documented and reasoned medical opinion on the causation and characterization of the pulmonary mass. Dr. Robinette integrated the August 1990 radiographic evidence with Dr. Ferguson's findings and sufficiently explained his difference of opinion with Dr. Hansbarger's pathology report. Dr. Robinette's probative opinion helps establish rather than refute that the pulmonary lesion was a "large anthracotic mass" that was appropriately diagnosed as complicated pneumoconiosis.

## **Conclusion**

In summary, I conclude a) that the more probative lateral chest x-ray of August 21, 1990 establishes the presence of an opacity greater than one centimeter; and b) the other medical evidence in the record is insufficient to demonstrate that some other etiology is responsible for the large radiographic opacity in Mr. Blankenship's lung or that he did not have complicated pneumoconiosis in August 1990. Accordingly, I find that Mr. Blankenship had complicated pneumoconiosis as defined in 20 C.F.R. § 718.304 by August 21, 1990. Though he filed his claim several months later in April 1991, Mr. Blankenship has proven through the irrebuttable presumption under 20 C.F.R. § 718.304 that the onset of his total disability due to complicated pneumoconiosis had occurred by August 21, 1990. As a result, under 20 C.F.R. § 725.503 (b), his date of entitlement to black lung disability benefits is August 1, 1990.<sup>25</sup>

## **AUGMENTATION**

Based on the parties' stipulation of fact, and the two periods of marriage between Mr. and Mrs. Blankenship (DX 7, TR, page 37, and DX 119A), Mr. Blankenship's benefits will be augmented for his dependent spouse, Mrs. Blanche Blankenship, from the date of his entitlement of benefits through September 1992, the month preceding their divorce. Augmentation of benefits for Mrs. Blankenship shall resume effective the month of their re-marriage, April 1999.

## **ATTORNEY FEES**

Counsel for the Claimant has forty-five calendar days from receipt of this decision and order to submit an application for attorney fees in accordance with 20 C.F.R. §§ 725.365 and 725.366. With the application, counsel must attach a document showing service of the fee application upon all parties, including the Claimant. In light of the extensive litigation history in this case, counsel must provide a comprehensive, and inclusive, listing of all professional times, associated hourly rates for respective periods of time, and litigation costs, coupled with a summarization of the final totals, as well as documentation of previously approved attorney fee petitions. The other parties have thirty calendar days from receipt of the fee application to file an objection to the request. Absent an approved application, no fee may be charged for representation services associated with this claim.

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<sup>25</sup>I note that in its July 27, 1995 decision, the Benefits Review Board specifically rejected the Employer's argument that the surgical removal of the pulmonary mass in September 1990 caused Mr. Blankenship's entitlement to benefits to cease (DX 88, footnote 3).

## ORDER

The claim of MR. LLOYD BLANKENSHIP for disability benefits under the Act is **GRANTED**. The Employer, DOUBLE B MINING, INC, is ordered to:

1. Pay the Claimant, MR. LLOYD BLANKENSHIP, all disability benefits to which he is entitled under the Act and Regulations. Benefits shall commence August 1, 1990 and will be augmented for his dependent spouse, Mrs. Blanche Blankenship, from August 1, 1990 through September 30, 1992 and from April 1, 1999 and continuing.
2. Reimburse the Black Lung Disability Trust Fund, pursuant to 20 C.F.R. § 725.602, for all interim payments made by the Black Lung Disability Trust Fund to MR. LLOYD BLANKENSHIP.
3. Deduct, as appropriate, from the payments ordered in paragraph one, the amounts reimbursed to the Black Lung Disability Trust Fund as directed in paragraph two; and,
4. Pay to the Secretary of Labor interest as required pursuant to 20 C.F.R. § 725.608 (b).

**SO ORDERED:**

**A**

RICHARD T. STANSELL-GAMM  
Administrative Law Judge

Date Signed: September 8, 2005  
Washington, DC

**NOTICE OF APPEAL RIGHTS:** If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. See 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. See 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board. After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed. At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Donald S. Shire, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. See 20 C.F.R. § 725.481. If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).

